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# DIAGNOSIS AND TREATMENT OF HYDROCELE.*

BY

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The medical profession in general, and some surgeons in particular, have gradually developed a sort of contempt for some commonplace diseases like the common hydrocele. In hospital practice, at any rate in some of the bigger hospitals, there is a tendency to think light of Hydroceles. I have heard some surgeons and assistant surgeons saying "Oh! hydrocele is a house surgeon's job". But the surgeon with whom I was privileged to work during the past 8 years in the General Hospital, never thought light of hydroceles and he has inculcated by example and precept his favourite dictum "you should consider the radical operation for a hydrocele as a major operation and should be as scrupulous in the execution of its technique as you are in a Gastro-Jejunostomy." This surgeon, in all his work, has never sacrificed technique to unholy and spectacular speed. I would emphasize the fact that the average stay of a hydrocele patient in the hospital is equal to or greater than the average stay of a case of Gastro-Jejunostomy for pyloric stenosis. Sepsis is a very frequent sequel due to imperfect preparation of the parts and sometimes to faulty technique. Sepsis is preceded by haematoma which is invariably due to perfunctory haemostasis due to the unjustifiable desire to finish the operation in record time of 3 to 5 minutes. Cases of deaths after a hydrocele operation are not unknown. One of my cases whose wound healed perfectly developed meningitis of an aseptic nature and died on the tenth day after operation. He had low spinal anaesthesia with novocaine. I can recall two other fatal cases done by others on former occasions. One case developed erysipelas and died

* Read at a meeting of the South Indian Medical Union.

in the second week and the other developed a form of idiopathic tetanus and succumbed. Of course, these deaths are few and rare. But they afford a severe warning to all of us, never to think light of any operation, particularly hydrocele. One may justifiably ask "What is the need for discussing the diagnosis and treatment of hydrocele when everything about them is already known?". I may frankly mention that the last word has not been said on these topics. For instance we do not yet know the cause of the common idiopathic hydrocele and by long habit we have blinded ourselves to the belief that operation is the only treatment for hydrocele. I am going to prove from my limited experience, that there is no indication for operation in the majority of early cases of hydrocele and that the injection treatment is eminently successful in nearly all cases. I am also going to bring to the attention of practitioners the imperative necessity of diagnosing the nature of the contents of the enlarged cavity of the tunica vaginalis by transillumination methods. Hence the title of this paper.

## Diagnosis.

In the majority of cases the diagnosis is easy and obvious. Fluctuation is easily elicited by the usual test. If the swelling is unduly heavy, and especially when there is a history of trauma or tapping, we have to consider haematocele as a likely possibility. But in every case, transillumination, in a dark room if available, must be done. For use in the ordinary consulting room some form of transilluminoscope is a necessary desideratum. Hamilton Bailey (1936) has modelled a transilluminoscope costing about 10 shillings Using the same principle, I have devised a cheap and efficient transilluminoscope costing about 10 annas only. This I made by sheer accident. I had to purchase a hose-pipe in connection with the water-cooling system of my motor car. While I was playing with it in my hands, I noticed that the inner lining was of thick black rubber and the outer of red rubber. I thought that it should be an admirable transilluminoscope. I shaped one end of the tube 1 foot long and 1¼ inch internal diameter, so that it could fit my eye margins snugly and comfortably. I have used the instrument in hundreds of cases and I am convinced of its absolute reliability. The photograph shows the method of its use in a case of common hydrocele. Ordinary uncomplicated hydroceles show a characteristic brilliant red glow in trans-illuminoscopy, as contrasted with a faint or no glow in haematoceles and solid tumours of the testes. When both the fluctuation and transillumination tests are clearly positive the diagnosis is indubitable. In a case of encysted hydrocele of the cord,

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where by palpation, the nature was doubtful about the solidity or the fluidity of the tumour, trans-illumination clinched the diagnosis. Again in a case of thyroglossal cyst just below the lower border of the cricoid cartilage, transillumination settled the clear fluid nature of the lump, which, was thought by some to be an aberrant thyroid. The instrument being so cheap, every practitioner can make one for himself.

### Differential Diagnosis.

It is advisable to exclude secondary hydroceles due to filariasis or syphilitic disease of the testes, as the treatment varies. Tuberculosis of the epididymis is easily eliminated. Some teratomata of the testes may be so soft as to be fluctuating even. Transillumination may clear the doubt as also a careful abdominal palpation which may disclose retroperitoneal lumps in the upper abdomen. From hæmatocele and chylocele it can be diagnosed by transillumination. Diagnosis from an incarcerated hernia and its association with a reducible or irreducible hernia must be made absolutely clear by transillumination and other clinical diagnostic methods. Punctures of the gut are not unknown on the mistaken diagnosis of a hydrocle while attempting to tap the same, when really a hernia was present. Such mistakes are inexcusable.

### Treatment.

Tiny hydroceles holding less than two ounces of fluid, provided they are not increasing in size, can be ignored But in my experience, some patients, demand an operation even for minute hydroceles. I once operated on a patient whose right side contained two drachms of clear fluid and the left practically nothing. This patient could not be convinced and demanded the operation which was very reluctantly complied with. Life Insurance Companies, public service commissions and other authorities, make a fetish about hydroceles without any justification. A non-progressive small hydrocele has absolutely no risk and it is highly irksome to base normality of premiums and fitness for permanent service, on its alleged dangers. Still it is difficult to rectify this age-long misconception. Some cases of acute traumatic hydroceles get practically cured in the long run by a scrotal suspender. So I shall confine myself to the treatment of the common chronic idiopathic hydrocele. What is our aim in treating a case of hydrocele? The cavity of the tunica vaginalis, developmentally an obliterated diverticulum of the endothelium-lined peritoneal cavity, has a single layer of endothelial cells lining the parietal and the visceral layers Normally there is a slight fluid secretion which lubricates the cavity and facilitates, perhaps,

the movements of the testes in the scrotal sac which is subject to contraction and relaxation, on account of the dartos which itself reacts to changes of temperature in the air or bath. The dartos contracts with cold air and cold water and relaxes considerably in warm air and baths. For some reason, perhaps due to obstruction of the return venous flow in the pampiniform plexus of veins, there is increased secretion due to over activity of the endothelial cells.

If this increased secretion is not counterbalanced by increased absorption by the venules or lymphatics, stagnation ensues which results in a hydrocele. There are only two ways of dealing with this weeping endothelial closed cavity. One way is to destroy the endothelium by aseptic chemical irritants and the other method is by operation in which either the parietal tunica vaginalis is excised or the sac everted so that the endothelial surface faces outside in contact with the raw inner surface of the operated scrotum. In this method of eversion the endothelial cells, though they may continue to secrete for some time, eventually die out unable to cope with the increased absorption on account of the contact with the raw surface.

## Injection Method of Treatment.

*Indications.*—The injection method is eminently successful in small sized and fair sized hydroceles, with thin-walled sacs. I have adopted this method from 1931 on twelve of my cases in private practice and the eventual results exceeded my expectations. I must say that all the 12 cases, without any exception were cured. And if you examine any of the cases now, you will perhaps begin to doubt my veracity. I can only ask you to believe me and the patient's story. But if you have any doubt, please try it on your next case and examine the patient six months after the injection. I would request you not to form a judgment a fortnight or a month after the operation.

*Mode of action.*—The chemical, whatever be its nature, destroys the secreting endothelial cells. There is exudation of albuminous fluid in the small cavity, which perhaps by organization, which is a pretty long process, seals the parietal and visceral layers into a single layer of fibrous tissue. The exact pathology can only be worked out by experiment on animals. In the last case of mine, I thought I failed since after two months I found a fluctuating swelling. I wanted to tap and re-inject if possible. I did so. When I introduced the trocar l felt it not to enter a cavity with fluid but into a semi solid tissue. When I removed the trocar, keeping the canula, *in situ,* I noticed only a few drops of brownish fluid with a little blood. I removed the canula and sealed the puncture. He went on a pilgrimage and met me 4 months

afterwards. I examined him then and was surprised to find that everything was normal about the scrotum and its contents. One thing we must realize, and it is also advisable to warn the patients before hand, and that is, we must allow 3 to 6 months to estimate the result of the injection. The process of organization is slow but sure. For two to three weeks after the injection the scrotum increases in size, there is a little dragging sensation, a little heaviness but no pain. A scrotal suspender for a month after the injection, is advisable, if not absolutely necessary. This injection method of treatment will fail in big sized hydroceles with thick walls. So the method should not be discredited after trial in manifestly unsuitable cases. When judging the suitability of the case we must take into consideration the size, the thickness of the wall of the sac and the contractile power of the dartos. In a middle aged or old person with a stretched skin and an incontractible dartos, it is wise not to try the injection treatment. All my cases were young men, below 25 years, with thin walled sacs and small or of moderate size hydroceles.

*Technique of injection* —The technique is simplicity itself. It requires a medium sized trocar and canula, with a 2 c.c. record syringe whose nozzle must fit into the canula snugly. I have not so far succeeded in getting a proper nozzled syringe for my canula.* Till now I used a stout record needle attached to the syringe. I managed to pass the needle into the canula and into the cavity of the sac and inject. I have used 2 c.c. of Quinine urethrane P. D. & Co. or Bengal Immunity Coy. Both the products are satisfactory. No preparation of the part such as shaving etc., is necessary but it would satisfy our surgical conscience if we ask the patient to come to us after a hot water bath during which the scrotum should have received special attention. It is also advisable to sterilise our hands as if for a surgical operation. I have not used any sterile towels around the region, but they may be useful. The following are the points in the technique :

1. Painting a circular area with Liquor Iodide.

2. Anaesthetising with Ethyl chloride spray at the intended point of puncture which should be free from blood vessels.

3. Stabbing with trocar and canula.

4. Removal of the trocar.

5. Allowing the fluid to run out into a sterile kidney tray placed between the slightly abducted thighs.

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* Since this paper was prepared a local firm has made for me an adapter one end of which fits the nozzle of the syringe and the other end, the canula snugly.

6. When practically all the fluid has run out, which may be helped by a gentle squeeze of the dependent portions of the sac, the 2 c.c. syringe containing 2 c c. of Quinine Urethrane is fitted into the nozzle and the contents injected.

7. The syringe and canula are quickly withdrawn, the puncture point is pinched between the thumb and index finger of one hand and raised, while with the other hand a very gentle massage of the scrctum is done to allow the fluid to come in contact with tbe entire surface of the wall of the tunica vaginalis.

8. Sealing the puncture with collodion or Tr Benzoin Co.

9. After the seal is dry, one or two layers of sterile gauze are applied, some sterile cotton is put on and a suspensory bandage applied.

10. No bath for 48 hours. No cycling for a month but the patient can mind his usual avocations, as if nothing has happened.

It will thus be seen that the treatment is within the province of any general practitioner.

**Operative treatment.**

The operative treatment is well known but there are some points which should be carefully considered if we want the best results

*Indications.*—All cases which are unsuitable for injection treatment must be submitted to operation if a radical cure is desired. Palliative methods by tapping only, must be reserved for very old men who are bad risks.

*Preparation for operation.*—The scrotal skin needs extra care and thoroughness in preparation Nothing is more desirable as repeated washing with soap, hot water and brush. I would specially advise shaving a day before the actual preparation of the part as I have found patients roaring with burning sensation on the application of spirit or turpentine, immediately after shaving. For delicate skins too much rubbing with irritants like Turpentine, Iodine and picric acid should be avoided. More reliance must be placed on thorough washing and scrubbing with hot water and soap.

*Anaesthesia* —Low spinal is eminently suitable and scrupulous precautions must be taken to prepare the back as if for a surgical operation. General anaesthesia may be used. I am against Evipan as I do not like to sacrifice technique in favour of speed..

*Incision.*—I have used mid-line incisions, para median incisions, and in a few cases transverse incisions also. I am not satisfied with the mid-line incisions as primary union is not firm for sometime. The transverse incision is needless. The paramedian is the best as the blood supply is greater than in a mid-line incision. Though the main incision is placed over the side of the hydrocele or the bigger of the two hydroceles, it has been my invariable practice to deal with the normal side also at the same time through the same incision, so as to prevent a future hydrocele. In very big double hydroceles, bilateral incisions may profitably be made. In the same cases, there is no need to make big incisions. A moderate incision can be made, tunica exposed and tapped, and then the sac can be isolated by blunt dissection and brought out.

*Compartmental System.*—After eversion it is better to put each testes into its own compartment and stitched with catgut In the old method of shoving both the testes into one cavity, I have heard complaints from patients that the testes have fused together at the lower poles in a horse shoe manner. This compartmental system is nothing extraordinary. It only brings on the restoration of the normal anatomy to the maximum extent possible.

*Thorough haemostasis* is essential. Even the smaller oozing point should receive attention.

*Excision of the parietal layer of the tunica vaginalis.*—In big and thick-walled sacs, excision should be the method of choice.

*Question of orchidectomy.*—In the middle-aged and old persons, when dealing with long standing haematoceles with organised blood clots and calcified walls, it is better to remove the organ provided the other is fairly normal and functioning. This will save a lot of post-operative suppuration.

*Drainage.*—When in doubt it is better to drain for 24 hours though drainage is unnecessary in the majority of cases.

*Dressing.*—One dressing after 48 hours and another on the 8th day, at the time of suture removal are the only ones needed in normal cases.

## Summary.

1. Hydroceles should not be thought of lightly.

2. Transilluminoscopy is strongly indicated in the diagnosis The author's cheap modification of Hamilton Bailey's transilluminoscope is described.

3. Injection method of treatment of certain types of hydroceles is strongly advocated.

4. Some pitfalls in the operative treatment are considered and their management dealt with.

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# "MANDYAM" AN ANAPHYLACTIC ATTACK IN CHILDREN?

By

A. V. S. SARMA, M.B.B.S.

It is the common experience of every general practitioner to see a child brought with an "Attack of Mandyam". A definite understanding of the same is wanting as observed by an absence of a description of the above condition in any treatise on pediatrics.

## The Clinical Picture.

*General.*—A child generally below 2 years of age is semi-conscious. There is generally excessive mucoid salivation dribbling from the mouth, mucoid discharge from the angles of the eyes and from the nares. The hands and feet feel generally chill while the abdomen feels definitely warm. The chest is heaving and the abdomen bloated.

Axillary temperature is usually 98° or 99° and rarely over 99°F. The pulse rate is between 120 and 130 per minute. The respiratory rate cannot be definitely counted because of the breath-catching phases.

*Special.—Digestive system*—Tongue is coated and the breath is generally foul. The abdomen is tympanitic and the liver feels a little larger than in children of the same age. The spleen is generally not palpable. The bladder is also generally distended. There is obviously retention of faeces and urine for larger periods during the "attack (?)". Auscultation over the right iliac fossa generally reveals sounds of restless intestinal contents.

*Respiratory system*:—(*a*) Inspection.—There is a slight rapidity of breathing and occasionally "cooing" sounds are heard. Sulcus-formation at the sides of the chest is seen at the end of every inspiration (like Harrison's sulcus of Rickets); (*b*) Palpation.—This confirms inspection; (*c*) Auscultation.—In typical and severe cases sonorous and sibilant rhonchi are heard all over the chest but over the bases moist sounds are occasionally heard; (*d*) Percussion—Nothing definite could be made. No dullness could be elicited anywhere.

*Heart.*—Rapidity of heart sounds and in older children a systolic murmur (generally accentuated during the "Attack") are heard. The systolic murmur is not confined to any one area and is heard in only older children, who have had repeated "attacks".

*Etiological Factors.*—I have studied about 50 cases of infantile biliary cirrhosis during the last four years and noticed that children who exhibit these "attacks" invariably develop in later months hepatic cirrhosis. Hence

I am forced to believe that the etiological factors of these " attacks " and infantile liver run parallel.

I have observed at least about 20 children with "attacks of mandyam" during the last 2 years and such of those etiological factors common to infantile liver and "attack of mandyam" are described below.

*Predisposing factors.*—

1. Race, caste etc.,—The common victims are children of the brahmin and vegetarian public.

2. Age, sex etc.,—A child gets an "attack" generally after six months. I have seen a case in a child of 3 months. Both sexes are liable to the attacks.

3. Heredity.—This occurs in children of the same family, and is hereditary in the sense that asthma is hereditary.

4. Tuberculous parentage.—Most of the cases (about 50 percent are children of tuberculous parentage.)

5. Congenital syphilis —This has certainly an important bearing.

6. Other morbid conditions.—There is a history of asthma or migraine, or urticaria or hepatic disease in famlies wherein the children are susceptible to the anaphylactic attack. Children born of mothers with toxæmias of pregnancy seem to be more prone to these ' attacks.'

*Exciting Factors* —1. Bacterial—Focal sepsis—chronic nasopharyngeal sepsis and otitis do seem to supply the infective factors which periodically intoxicate the system and raise these attacks.

2. Nonbacterial.—Drugs like opium derivatives and castor oil. Opium or its derivatives given to bind the bowels in a case of intractable diarrhoea sets up an attack.

Children who get these " attacks " are generally constipated and to overcome this, castor oil is administered early in the morning. The drug answers the purpose in some cases with unusually many motions, and by the evening the child has a ***high temperature*** and respiratory spasm. Sometimes the child has no motions as the castor oil is retained to a more or less extent and the child is seen by the evening with ***a distended abdomen, slight fever,*** and difficulty in breathing.

(*b*) *Food factors.*—Certain items of diet start the ' attack ' in some older children. Preparations of dhall, flour, ghee, and irritant or fibrous foods are important as causative agent in this direction.

(*c*) Helminthiasis.—This is also a probable cause.

(*d*) Preventive vaccination against small-pox.—Some children, (especially those with tuberculous diathesis) who undergo vaccination develop during or after the reaction hepatic torpor and respiratory spasm.

*Course.*—While a mild attack clears in a day or two a severe attack subsides only in about a week.

*Diagnosis*—Conditions simulating it (influenza, severe constipation, acute bronchitis, Broncho-pnuemonia) have not the spasm, characteristic of the disorder in question.

*Prognosis.*—This is generally good though I have heard from parents that some children have died during a "breath-catch" characteristic of the disease.

*Treatment.*—The following procedure did much good.

1. Warm dress. Liquid diet.

2. Glycerine suppository (when tympanites is present) at the time of observation.

3. A small dose of pituitrin (0. 1cc. to 0.25 cc.) given hypodermically relieves the spasm within an hour—A quick voidance of urine and motion and cessation of respiratory spasm are had.

4. A diaphoretic mixture is given and Grey powder or calomel (when congenital syphilis is suspected).

5. Specific treatment consisted in the administration of Vitamin C which definitely cures the attack. On theoretical grounds adrenalin cortex deserves a trial.

6. Nutritious and balanced food, and healthy surroundings are essential to prevent recurrences. Vitamins A, B, C, and D, calcium and phosphorous, are also useful.

*Discussion.*—There is definite morbidity in families wherein children get the above mentioned "attack". This suggests a congenital predisposition to the disorder.

The respiratory spasm is similar to asthma in adults and apparently there is an anaphylactic element (vagal spasm ?) The exciting factor may be bacterial, or non-bacterial or of the nature of a ptomaine.

# MEMORANDUM SUBMITTED TO THE GOVERNMENT.

From

M. R. Ry., T. SATAKOPAN, AVL., M.D.,

*Secretary,*

*The South Indian Medical Union, Madras.*

To

THE SECRETARY

*to the Government in the Ministry*

*of Public Health, Madras.*

Sir,

By direction of the Union, I have the honour to forward to you its considered views on the recent G. O. No. 3,600 P. H., dated 23rd December 1937 as regards the re-organization of Medical Relief in this Province, specially the rules governing the system of staffing the public institutions with practitioners in an honorary capacity.

It was generally believed that the Government would publish their proposals for eliciting public opinion before they finally passed orders. The Union regrets that it had not this opportunity of expressing its views before the Government arrived at their decision. But the Union feels it its duty to bring to the notice of the Government some at least of the difficulties that will be experienced by practitioners and the public on account of the new rules. It hopes that where the Government are convinced of the correctness of the remarks they would see their way to amend the rules speedily.

The Union is glad that in the new order, the Government have generally accepted the recommendation of the last Honorary Committee presided over by Major-General Sprawson, the then Surgeon-General with the Government of Madras. The above Committee was unanimous in its recommendation,

(*a*) that Honorary Medical Officers should be appointed to be in full charge of Dispensaries and small hospitals,

(*b*) that Honorary Medical Officers should be eligible for Professorships and Lecturerships in the Schools and Colleges,

(*c*) that Honorary Medical Officers should replace paid Medical Officers as vacancies occur, and

(*d*) that the Government should extend the system of employing Honorary Medical Officers.

The Union considers that by accepting these recommendations and agreeing to bring them into effect immediately the Government have taken the Honorary Scheme many steps forward. It is hoped that exigencies of service or other considerations would not be allowed to delay the working of the scheme very long.

*Classification of Honorary Medical Officers.*—It is not obvious in the published rules whether the terms Honorary House-Surgeons and Physicians mentioned in the G. O. also cover the present House-Surgeons and House-Physicians. The Union believes that newly qualified graduates and licentiates who work in hospitals as Panel House-Physicians and House-Surgeons, paid or unpaid will be treated apart as at present. They should not be included in the new group of Honorary House-Surgeons or House-Physicians.

The terms Honorary Physicians and Surgeons undesirable.

In the present working of the honorary scheme, graduates or licentiates who have finished their training as House-Surgeons and House-Physicians are entertained as honorary clinical assistants. The Government evidently wish to abolish this grade. The Union fully agrees that the terms clinical assistant is ambiguous and as such welcomes its abolition. Fully qualified medical men should be entertained as Honorary Assistant Physicians or Surgeons. But the introduction of another class known as Honorary House-Surgeons and House-Physicians merely complicates the nomenclature of honorary medical officers. It is possible that this denomination is meant for Licentiate honorary medical officers. But the terms House-Surgeon and House-Physician are definitely associated with freshly qualified medical men who work in hospitals to gain practical experience and who are not allowed to practise outside the hospitals. Therefore it will be anomalous if the same terms are applied to medical men who may have long past that stage and who may be already in practice. The Union, therefore, considers that there should be only two grades of honorary medical officers, namely honorary assistant medical officers and honorary medical officers. But if the Government still

feel it necessary to have another grade a more suitable nomenclature should be decided on in the place of the terms Honorary House-Surgeon or Physician.

*Payment of Honorarium.*—The Honorary Medical Officers at present employed in the various hospitals do not receive any allowance. The Government evidently wish to grant them some allowances. But it is not quite clear on what plan they propose to pay these allowances. If all future entrants are to receive the honorarium it is quite correct. But if among these only those who replace paid men are to receive the allowance, we submit that such invidious distinction born of an accident as to when a particular practitioner is appointed is undesirable.

All future entrants should be treated similarly as regards allowances.

If the Government desire that Honorary Officers should be paid an allowance, there should be no option given to individual members to refuse the allowance. For, such a provision will create among some members an undesirable feeling of fictitious superiority. If allowances are to be given, the junior members should get more; the seniors need not be paid any allowance. Nevertheless, honorary medical officers employed as professors and lecturers should be paid for academic teaching work.

No option to refuse honorarium.

In the waiting period of their practice Junior medical men should be helped with a subsidy which would reasonably enable them to establish themselves, especially in parts of the province where such practice has to be newly developed. We believe that this is also the intention of the Government. But the allowances fixed by the Government are certainly very meagre. And it would be very unfortunate if the public should come to believe that with such allowances the State is paying medical men living wages.

The Union therefore wishes to protest emphatically against the fixing of such poor allowances. The giving of such allowances merely suggests help without actually rendering it. But in view of the declared scarcity of funds to finance medical relief, the Union respectfully suggests that allowances should be given to the Honorary Assistant Medical Officers for the first five years as follows: Rs. 75 per month for the first two years and Rs. 50 per month for the next three years. After which period of five years honorary medical officers need not be paid any allowance.

*Tenure of Appointments.*—The Union strongly holds that the idea of fixing a limited tenure is objectionable and unnecessary for the following reasons :

Lack incentive to voluntary service.

The chief object of young men joining honorary appointments is their ambition to chalk out careers for themselves. If the young doctor knows that he is to be pulled up at the end of every five years, there will be no incentive to voluntary service. It is true that in the present state of the country and the deplorable condition of the profession, a large number of practising doctors may be available to man the hospitals and dispensaries on conditions laid down by the Government however irksome and unfair such conditions may be. But the Union is confident that it is not the intention of the Government to create or encourage such undesirable conditions

Over-crowding of practitioners tends to impair efficiency of institutions.

One of the main reasons for the very poor living of many practitioners in this province, is the over-crowding in certain areas, while vast tracts of the country carry hardly a qualified practitioner. A more reasonable distribution of the practitioners will enable them to thrive better. There was great unwillingness on the part of practitioners to settle down in small towns. There is a welcome change in this attitude. It is in the power of the Government greatly to encourage this tendency by the judicious appointment of honorary medical officers to the hospitals in smaller towns. But if a tenure of five years is to be the ordinary rule, each hospital area will in course of time carry a larger number of medical practitioners that it could support. Because, every five years a fresh set of men who are appointed to the hospital will arrive, while the retiring men are bound to settle down in the place where they have worked for five years of their formative period. If in spite of these difficulties medical practitioners volunteer to work in the hospitals and dispensaries it would be difficult for them to be enthusiastic in their services to the institutions concerned.

Practitioners cannot attain high efficiency.

If a new set of Honorary Medical Officers is to be appointed every five years, there will be no experienced medical men at all in charge of the hospitals except the fully salaried Government Medical Officer. And since the latter will be more concerned about the administrative duties, such periodic change of medical officers would adversely affect the efficiency of the institution. Thereby the public would suffer. Further every time the public or the

profession demand the curtailment of private practice of salaried medical officers, the argument is advanced that the public should not be denied the benefit of the high efficiency of the experienced hospital doctors. By this tenure, the honorary medical officers will be totally denied the opportunity to attain this high level of efficiency. This will therefore perpetuate the existing monopoly of all consultant and better grade practice by the salaried government medical officer in charge of the hospitals.

Difficulty of securing Senior officers and Teachers.

It is mentioned in the G. O. (Rule 6, item. 3) that the appointment of an Honorary Assistant Medical officer as an Honorary Physician or Surgeon will depend also on his experience as an Honorary Assistant Medical Officer. By this five years period, the necessary experience is curtailed. Without the necessary continuity of tenure, there will be hardly any incentive for them to spend the time and money to equip themselves with higher academic qualification. And therefore it would be increasingly difficult in future for the Government to find a sufficient number of competent senior practitioners to hold the post of honorary physicians and surgeons. Much less would it be possible to get professors and lecturers. It is therefore essential to have a large number of juniors who can look forward to occupying senior posts in time.

To achieve this purpose the Union is of opinion that honorary assistant medical officers in teaching and other hospitals in the City of Madras and Vizagapatam should equip themselves with a higher degree or diploma, or should have to their credit original work of approved merit within the first five years of their tenure. If any of them fail so to equip themselves, their service in such institutions may be terminated.

The idea of tenure and possible re-employment tends to place the Honorary Officers under the absolute mercy of the District Medical Officers since the latter's opinion is likely to tell most when re-employment is under consideration.

With the provision in the rules (Rule 22) for liberty to the Government to terminate the services of Honorary Medical Officers at their pleasure, the fixing of a five years' tenure is unnecessary. Further, the rule whereby promotion of an Honorary assistant Medical Officer to the rank of a Physician or Surgeon is made to depend on certain condition, is sufficient safeguard against the continuance of unsatisfactory officers.

If the object of the tenure is merely to give opportunities for a large number of practitioners to get the benefit of the hospital training, the Union

believes that for a number of years to come there will be room practically for all medical men who are in a position to work in hospitals to be so employed.

*Period of duty in the institutions.*—It is mentioned that honorary medical officers should spend at least three hours of the best part of the day in the hospitals. Such hard and fast rules are unnecessary. The time required to be spent depends on the amount of work, the number of beds and the nature of the cases at the time. In some places there may be hardly work for an hour. In others, and on occasions, the medical officer may have to spend three hours or even more. In many institutions it would often be impossible to spend three hours usefully in the wards. Further the duties of honorary medical officers in teaching hospitals require more time than in non-teaching institutions. Therefore a *proviso* that honorary medical officers should be in the hospitals sufficiently long to complete their work should be enough.

*Hospitalization of Private Patients.*—After Rule No. 10 which requires that honorary medical officers must abide by the Government rules in force in regard to the acceptance of fees from patients by the staff of the hospital, the Union fails to understand the necessity or the purpose of the various clauses under rule No. 14. Nothing even remotely resembling these "shall not's" has found a place in the rules governing the honorary medical scheme upto now. That it should now be considered necessary to introduce this rule leads one to the conclusion that the Government has strong reasons to be dissatisfied with the conduct of the present honorary medical officers. It is difficult to appreciate this attitude of the Government which has often testified to the success of the scheme and which even in the first clause of the G. O. under consideration declares that the system has on the whole worked satisfactorily. Encouraged by the success of the system the Government desires to utilise to a greater extent the willing services of the practitioners for the benefit of the public and for their own financial advantage. The Union is therefore painfully surprised that the Government should consider it right to introduce this rule which is certain to create an impression in the public mind that honorary medical officers cannot be trusted to their honour and that they require these punitive rules to keep straight. The Union therefore hopes that the Government will be agreeable to delete this rule before they begin the extension of the honorary scheme.

If it is the idea of the Government that patients who have consulted the medical officers outside should not be admitted into the wards under

their care, the Government should say so and make the rule absolute and applicable to all medical officers of the institution.

But this rule is practically impossible to work in the case of honorary medical officers who are in charge of special departments. By virtue of his being the only person to deal with such cases in the hospital, patients whom he recommends should be admitted in the hospital will naturally be admitted under his care.

If an honorary medical officer sees a patient in his private office and finds that hospitalization is necessary and advises him accordingly, it may so chance that the patient finds his way into the particular officer's ward by the application of rules of admission obtaining in the institution. The medical officer can hardly be blamed for the admission of the particular patient.

If the Government is desirous of putting down the abuse of hospital privileges in the matter of admission of patients, the Union suggests that the most useful plan would be to appoint a capable and responsible officer in each major institution to scrutinize the social status and income of the patients who seek admission into the hospital. If this scrutiny is carefully done a good deal of abuse is likely to be prevented.

*Duties of Honorary Medical Officers.*—It is laid down that the duties of the honorary medical officers would be allocated by the Superintendents in the City hospitals and the District Medical Officers in the districts. This arrangement has been the cause of much trouble and confusion in the past, giving rise to friction and complaints. It would be very much more helpful to the better working of the Scheme if the duties are laid down by the Surgeon-General after consultation with the Superintendent or District Medical Officers and the Honorary Officers.

*Discipline.*—The new G. O. perpetuates the existing rule that the Superintendent of the City hospitals and District Medical Officers in the districts are solely responsible for the management and control of Government medical institutions. The Union recommends that these matters should be attended to by a committee of the hospital staff with the Superintendent as the Chairman.

I have the honour to be,

Sir,

Your most obedient servant,

(Sd.) T. SATAKOPAN,

*Secretary.*

# JOURNAL OF SOUTH INDIAN MEDICINE

FEBRUARY, 1938.


## SOCIALISED MEDICINE.

We are publishing in this issue of the Journal the text of the Memorandum submitted to the Government about the recent reorganisation of the honorary scheme in this province. Most of it has already been published in the local press. We have also seen in the local dailies some of the recommendations of the various District Medical Associations on the subject. We are pleased to know that the profession as a whole is in agreement with the views expressed in the memorandum of the Union. But there appears to be a little difference in the views about the desirability of fixing a limited tenure. We shall be very happy if such of those Medical Associations who differ from us would reconsider their views in the light of the observations contained in the memorandum. The Scheme is primarily intended to increase the facilities for medical relief of the province. But it is bound to affect very much the prospects of the medical profession in the near future. It is therefore essential that the profession should continue to devote some thought on this subject. This is specially necessary, since the rules which have been framed to guide the working of the scheme are not to be taken as final. We have it on the authority of the Government that they would not hesitate to amend the rules where they are found to be unsuitable in the actual working.

In the meantime the publication of the views of the local Government on the policy of medical relief in the future, has given rise to much criticism of the honorary medical scheme itself. There are at present three views held as to the best means of rendering medical relief to the people of the province. Those who have for so long been used to the various cadres of salaried medical men looking after the hospitals and dispensaries feel that there will be a serious setback to progress of medical relief if the various institutions are to be manned by well qualified practitioners in an honorary capacity. There is again a group that feels that the State should be completely responsible for all medical relief and that the organisation should

be modelled on what is said to occur in Soviet Russia. Thirdly there is the group that believes in the middle path of utilising paid services and independent practitioners to extend medical relief.

Those who advocate rendering medical relief by means of well paid full time medical Services ignore the present impossibility of financing such a scheme. We do not believe that the country is so poor that we cannot spend much more on medical relief. Disease is rampant. Much of it could be prevented, and a good deal could be easily and early cured if facilities are available. It must be the State's endeavour fo find the money for both. And with proper planning a vast deal more could be done in both directions. It would be foolish to plead poverty from house tops and keep vacantly staring at the unending march of disease and death below. But it would be even more foolish to scrape up the available money and lavish it on the medical personnel while hospital accommodation is meagre and dispensaries are scarce as the rains in summer.

It would therefore be wise to utilise the money available for constructing new clinical centres and enlarging the existing hospitals and for equipping them with the necessary appliances. But then what would be the use of building hospitals and equipping dispensaries if there are not the medical staff to attend to the patients? And why should medical men alone be the unpaid agents while everybody else connected with the medical relief is paid adequately? Those who argue thus generally ignore the fact that whether a medical man is paid by the State or whether he depends on his living on the fees of his patients, the money comes ultimately from the people. Those who advocate the institution of State insurance schemes for health also seem to think that there is a good deal of difference between this and the prevalent method of medical relief whereby the State provides the public with well educated medical men and leaves it to the former to utilize their services as best as they can.

These questions have been before now discussed with great learning and vehemence by experts in economics and professors of socialism. But to the average man it is just a bewildering array of arguments and proposals. It is not yet convincing as to

which is the best method, whether the State should tax the people more than fully and cater to all their needs, or whether direct taxation should be just sufficient to organize certain essential and common services and leave the rest to the commonsense of the public. The choice of the method would depend a good deal on the psychology of the nation that is concerned. As such we feel that the policy that is being gradually evolved in Madras is the one that is most likely to be useful in the interests of the public. The policy of associating the practitioners with the public institutions serves the two purposes of medical relief. It makes available to the public a large number of well qualified practitioners for those who require individualistic attention and the poorer public has the same skill and knowledge available in the State medical institutions. In recommending the honorary scheme to the appreciation of the public, we do not minimise its defects. The success of the policy will depend on the sincerity and enthusiasm with which it is worked. We earnestly hope that the authorities will insist on the presence of these qualities in the working of the honorary scheme.

* * * *

We regret very much that many errors have crept into the article "Pitfalls of Ophthalmology" published in the issue of December 1937. The printers unfortunately made use of an uncorrected proof instead of the right one. We hope to make amends by republishing the corrected article in the next issue of the Journal.

# LEPROSY

## CHAULMOOGRADINE

While Chaulmoogradine tablets may not adequately replace injection treatment of Leprosy, they are nevertheless very useful for reinforcing injection of chaulmoogra preparations, as a maintenance treatment between courses of injections and as a precautionary treatment against relapse following the cessation of injections.

Relapse often occurs through treatment being stopped too soon. Sometimes a complicating disease may suppress the cellular reaction to the B. Leprae, as a result of which the disease may appear to be arrested, but actually is only quiescent.

The administration of Chaulmoogradine tablets at the cessation of injection treatment will serve to maintain resistance to the B. Leprae, and reduce the danger of relapse.

The tablets are composed of salts of the total unsaturated fatty acids present in chaulmoogra oil; they are convenient to take and remarkably free from any deleterious action on the stomach.

COMPOSITION: Gluten coated tablets each containing ½ gram of the sodium salts of Chaulmoogric and Hydnocarpic acids.

ADVANTAGE: The gluten coating prevents gastric disturbances.

DOSE: One tablet three times a day, which may be increased to six tablets per day in some cases.

PACKING: Bottles of 100 tablets.

## PHARMASOL CHAULMOOGRA

COMPOSITION: A colloidal preparation of Chaulmoogra oil.

| Strengths | Ampoules | Vials. |
|---|---|---|
| 0·1 per cent. | 2 cc and 5 cc | 25 cc |
| 0·2 " " | 2 cc | 25 cc |
| 0·5 " " | 2 cc | 25 cc |
| 1·0 " " | | 25 cc |
| 2·5 " " | | 25 cc |

DOSAGE: Begin with ½ to 2 cc of 0·1 per cent every 2nd day. Gradually increase the dose and interval till 5 cc or more of 1·0 per cent or 2·5 per cent is given once a week.

METHODS: Intramuscular or intravenous as convenient.

ADVANTAGES: No venous occlusions.

The Anglo-French Drug Co. (Estn.) Ltd.,

P. O. Box 460 — BOMBAY.

# ASSOCIATION NOTES.

## KISTNA DISTRICT SUBSIDIZED RURAL MEDICAL PRACTITIONERS' ASSOCIATION.

I. Resolved to request the Managing Editor 'The Medical Practitioner, Madras', while drawing his attention to the resolutions Nos. 8 and 9 passed in the Provincial Conference of 10-7-37, to keep the subscription rate of his journal at Rs 2-8-0 per year for all the Rural Practitioners.

II. This Association strongly protests against the action taken by the Kistna District Board in dispensing with the services of the Rural Medical Practitioner, Pallevada (Kaikalur Taluk) who has been in charge of the dispensary ever since the beginning of the Rural scheme on the simple ground that the District Medical Officer, Kistna, has recommended the Practitioner for a refresher course of 3 months at the District Head Quarters Hospital, Masulipatam and resolves to request the President, District Board, Kistna to rescind his orders which are not consistent with the terms of the agreement and to reinstate the Practitioner immediately.

III. This Association while expressing its gratitude to the Government for the G. O. No. 3066 P. H. dated 15-11-'37 has reasons to apprehend that the local bodies may utilise the same for removing some practitioners from their stations on political reasons which do not at all concern the Rural Dispensaries and therefore resolves to request the Government to add a sub-clause to the above G. O. that the considerations of the District Boards to shift the existing dispensaries should also include the opinion of the practitioners concerned besides those of the District Medical Officers and regarding the population of the village the work of the dispensary and other facilities which may justify retention.

IV. There are rumours that the Government intend to enforce Vaccination and Public Health Work on the Rural Practitioners for Villages within a radius of 5 miles with a paltry honorarium of Rs. 15 per month. As such an enforcement entails loss of private practice, the Association resolves to request the Government to drop such a proposal and give the practitioners supervising work only on the preventive side with a Vaccinator as an assistant and an honorarium of Rs. 30 per month in accordance to the resolution passed at the recent Provincial R.M.P. Conference held on 10-7-'37.

V. This Association requests the Government to enforce the local bodies for supplying raw Indian Drugs to all the Rural Practitioners of Indian Medicine working under them thus enabling the practitioners to manufacture genuine medicines themselves as the medicines now supplied are being found most ingenuine.

The undermentioned resolutions unanimously passed at a meeting of the Kistna District Subsidized Rural Medical Practitioners' Association held at Masulipatam in D.M.O.'s Office premises on Saturday 19-2-'38 at 3 p.m.

# RAMNAD DISTRICT MEDICAL ASSOCIATION.

(Branch of the Indian Medical Association.)

*December, 1937.*

The December Meeting of the Association was an extraordinary general body meeting held at the S. M. S. High School, Karaikudi on the 18th December, 1937 when 13 members were present and four were represented by proxies. In the absence of both the President and the Vice-President Dr. M. S. Krishnaswami was voted to the chair.

The following resolutions were adopted :

1. This Association be made a branch of the Indian Medical Association; also the members may be classified into two groups, namely, regular members who become automatically members of the Indian Medical Association and Associate Members who are only Associate Members of Ramnad District Medical Association without vote in business matters.

2. This Association be made into a Branch of the Indian Medical Association forthwith and the Secretary is authorised to remit Rs. 1/8, per paid members being the half yearly dues to the I. M. A. and also communicate the addresses of these members.

3. This Association requests the Government that, in the new Madras Medical Council Act to be passed by the Madras Legislature, in the elected members to the Council proper and proportionate representation of the following groups of Practitioners—Independent Medical Practitioners, Rural Medical Practitioners, and Municipal and Local Board Employees be given, in the election according to their electoral strength.

With the vote of thanks the meeting terminated.

*January 1938.*

A Special meeting of the Association was held at Kanadukathan in Dr. T. S. Shetty's Clinic on the 4th January, 1938. There was a large gathering of 35 from Ramnad District, 8 from Pudukotah State, 6 from Madura and 5 from Trichinopoly. Captain B. Dayananda Rao occupied the chair.

Professor Dr. Rudolf Demel of Vienna who was to have addressed the gathering on " Treatment of acute suppurative and phlegmanous diseases " could not be present owing to unforeseen and unavoidable circumstances and it was a sad disappointment to all present.

Those assembled were entertained to tea by Dr. T. S. Shetty. The minutes of the December Meeting were read and adopted. In his opening speech the President gave his impressions of the All India Medical Conference held at Madras during Christmas Week.

Dr. S. Subramanian opened a discussion on the Honorary Medical Officers Scheme and Drs. M. V. Natesan of Madura, Kalmegam of Trichinopoly, Shetty of Kanadukathan and the President took part in the discussions. The following resolution was adopted.

This Association welcomes the Honorary Scheme as expounded by the Government in the recent communique and appoints a committee to consider any modifications to the scheme, the committee being Captain B. D. Rao, Drs. N C. Appayya, S. Subramaniam, T. S. Shetty, S. Rajaram Bharathi and K. S. Srinivas.

With the vote of thanks the gathering dispersed after dinner, the host being Dr. T. S. Shetty.

*February, 1938.*

The February meeting was held at the Swedish Mission Hospital, Tirupattur on the 19th February, 1938 with the President of the Association Captain B. Dayananda Rao in the chair. Those present were entertained to tea by the staff of the Swedish Mission Hospital and there were 33 doctors present.

The minutes of the last meeting held at Kanadukathan was read by the Secretary and adopted. The Secretary announced that the Special Committees' recommendations on the scheme of Government on the Honorary Medical Services were considered by the Managing Committee and read the proceedings of the managing committee for approval at the meeting. The following resolutions were carried :—

1. The proposal of the managing committee that the President of the Association be the representative of this Branch on the central council of the Indian Medical Association was approved.

2. The nomination of Dr. N. C. Appayya to be the representative of this Association on the Ramnad District Leprosy Council was also approved.

3. Resolved that this Association requests the Government that they may be pleased to provincialise the services of the Medical Officers under Local Boards and Municipalities as in the case of other officers connected with Local Bodies.

4. Resolved that this Association welcomes whole-heartedly the scheme of the Government in the matter of Honorary Medical Services and is of opinion that no allowances need be paid to the Honorary Medical Officers other than a conveyance allowance ranging from Rs. 20 to 50, this allowance being paid at the discretion of the Government and only when applied for.

5. Resolved that every Honorary Medical Officer appointed to a post shall be entitled to promotion to the higher cadre only on his merits irrespective of the academic qualifications.

6. Resolved that this Association favours the formation of the Provincial Branch of the Indian Medical Association at Madras.

7. Resolved that the annual gathering may be arranged to take place about the end of March or beginning of April, 1938 and the Secretary in consultation with the President to do the needful.

8. The Secretary was authorised to communicate these resolutions to the authorities concerned.

Sister K. Wilcke, R. N., of the Swedish Mission Hospital read a paper on "Some thoughts regarding the Nursing Profession in India." There was some discussion on the subject in which Dr. Subramanian and the President took part.

An interesting case report was given by Dr. F. Ysander and it was one of a mixed tumour—Chondro sarcoma ?—of the ankle in a boy of 13 which developed after an injury and which simulated Chronic Osteomyelitis.

The proceedings came to a close with the vote of thanks by the Secretary to the lecturer, the hosts of the evening—the staff of the Swedish Mission Hospital, the Chairman of the meeting and to the members who attended in large numbers. The Secretary informed the gathering that the Surgeon-General with the Government of Madras was likely to attend the ensuing annual meeting and hoped for a grand success of the anniversary.

## 'THE INDEPENDENT MEDICAL PRACTITIONERS' ASSOCIATION, TINNEVELLY.'

A meeting of the above Association was held on Saturday the 15th January 1938 at 6 p.m., at Dr. L. Mahadevan's Eye Hospital under the presidentship of Dr. R. Sundaram, M.D., Retired D.M.O, Tinnevelly when Dr. V. Narayanachari, L M.P. read an interesting paper on 'Some common skin diseases'. The speaker dealt with almost all common skin conditions and mentioned especially the value of Milk therapy, Cal. salts and auto-urine therapy in the treatment of Psoriasis and Eczema. He also mentioned the use of various drugs in the treatment of Ringworm, scabies, and other conditions of staphylo or streptococcal origin. There was then some discussion after which he mentioned briefly how and when auto urine therapy is carried out.

The meeting then terminated with a vote of thanks by the Secretary to the President, lecturer and members.

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# NOTICE.

## THE MADRAS MEDICAL REGISTRATION DEPARTMENT.

DEAR SIR,

There appears to be some misunderstanding about the Notification dated 10th January 1938 published by this Office in the Fort St. George Gazette and the Local Dailies and a copy of which was sent to you for favour of publication in your Medical Journal.

Persons who have already registered their names on the Madras Medical Register need not again apply for registration. The notification was meant only for persons possessing the qualification L. C. P. & S. of India or any other similar qualification (not included in the schedule to the Madras Medical Registration Act), a few possessing such qualifications having been registered in the past by the Madras Medical Council with the special permission of Government.

I shall be much obliged if you can kindly make your readers understand the position clearly.

(Sd.)

*Registrar.*

# NOTICE.

## ASSOCIATIONS OF SURGEONS IN INDIA.

At the request of the organizing secretaries we publish the following:

The objects of the Association are :—

(1) To advance the Science and Art of Surgery in India,

(2) To bring together Surgeons from all parts of India,

(3) To hold periodic meetings in different parts of India, where matters of Surgical interest will be discussed and social contact established,

(4) To publish a journal devoted to Surgery in all its branches,

and (5) To do such other things as will conduce to the above objects.

It has been proposed to hold the inaugural meeting of the Association of Surgeons at Bombay in the middle of April, 1938. At this meeting the rules for the conduct of the Association will be submitted and Office-bearers elected.

Your co-operation is requested and we shall be obliged if you will kindly let us know your views freely on this subject.

We would also request you to be a member and to attend the inaugural meeting at Bombay. The dates of the meeting will be communicated to you in March next, or earlier, if possible.

At the inaugural meeting, time will be set apart for discussion of papers on Surgical subjects. It is hoped that you will contribute papers to be discussed at this meeting and join in the discussion that will follow.

This Association is purely a Scientific one and will not take part in politics of any kind. It is hoped that Surgeons of all classes and nationalities practising in India, private practitioners and Government employees will join as members and help to make the Association strong.

This Association is an independent one and is not a branch or part of any other existing medical Association.

The membership is open not only to those who practise Surgery (including its branches) exclusively but also to others who practise it along with other branches of Medicine.